Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046049	A. BUILDING _____ B. WING _____	C 12/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citation represents the findings of Complaint Investigation #KS61545, #KS61449, and #KS61923.	S 000		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: The facility identified a census of 83 residents in Assisted Living. The sample included 3 residents. Based on record review, and interview, the facility failed to ensure one sampled resident (#1) received care and services in accordance with his/her assessment and Individualized Service Plan (ISP) regarding the prevention of falls which resulted in a fall with injury. Findings included: - Resident #1's Service Evaluation and Health Assessment dated 6/25/12 documented the resident was alert and oriented and with short and long term memory impairment. The Health assessment recorded the resident required assistance of one staff with transfers, mobility, grooming, and dressing. This same assessment documented the resident with occasional bladder incontinence, was at high risk for falls, had a history of falls and required constant redirection	S3155		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S3155	Continued From page 1 and reassurance. The ISP updated on 10/1/12 documented the resident required increased assistance with mobility, transfers, bathing and continence. The ISP recorded the resident was able to toilet him/herself when admitted, but now experienced increased episodes of bowel and bladder incontinence. This same service plan directed staff to notify therapy of any falls and to assess as appropriate. The ISP lacked any record of the resident's falls and/or any individualized interventions for the prevention of falls. Review of the residents fall investigations and progress notes revealed the 5 falls revealed the following: The resident progress notes dated 8/2/12 recorded at 2:00 P.M. the resident reported that he/she got up off the floor and crawled into his/her bed, called his/her spouse and the spouse called the facility and said the resident fell. The fall investigation report documented that staff notified therapy. Continued review revealed one therapy referral/screening dated 8/6/12 which recorded therapy was not indicated at that time. No additional interventions were implemented at this time. The fall investigation untimed and dated 9/4/12 recorded a staff member walked into the resident's apartment and found him/her on the floor. The resident sat outside the bathroom and stated that he/she slid/slipped and fell. The resident obtained a skin tear on his/her right elbow. The facility notified therapy and recorded this was a random fall coming out of the	S3155		

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S3155	Continued From page 2	S3155		

bathroom and staff removed rugs from the resident's bathroom.

The fall investigation untimed and dated 9/24/12 recorded staff found the resident on the floor in his/her apartment. Staff assisted the resident up from the floor. The resident had 2 falls this month with an overall decline, hospice to evaluate.

The investigation untimed and dated 9/30/12 recorded staff found the resident on the floor in his/her apartment on 9/29/12. The resident bumped the back of his/her head, staff checked for injuries and none noted and the resident stated his/her lower legs hurt. Staff notified the physician and family. This same investigation recorded "hospice to evaluate" the resident.

Review of the October 2012 physician's order sheet revealed resident #1 admitted to hospice services 10/3/12 for metastatic prostate cancer (cancer that spread outside of the prostate gland and affected other organs/bones).

Continued review of the fall investigation dated 11/4/12 revealed at 1:30 P.M. the resident did not use his/her call pendant after a fall, yelled for help, and staff found the resident on the floor in his/her apartment. The resident sustained a hematoma (localized collection of blood) to the right side of his/her head, a skin tear to his/her right arm, and pain to his/her right hip.

Continued review of the clinical record revealed the resident was admitted to the hospital on 11/4/12 for surgical repair of a fractured right femur (large leg/thigh bone) and re-admitted to the facility for skilled services on 11/9/12.

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S3155	Continued From page 3 0n 12/12/12 at 2:45 P.M. an interview with administrative nursing staff A acknowledged the resident's fall with injury and stated that he/she was unaware no therapy screenings were in the residents record. Administrative licensed nurse A acknowledged the resident's ISP did not include any new or individualized interventions and/or plan after the resident's falls. On 12/12/12 at 4:50 P.M. interview with administrative licensed nursing staff A explained the facility staff contacted therapies (after falls), the resident tried to be independent and we made sure the apartment was clean and uncluttered and we checked on him/her about every two hours. On 12/12/12 at 4:50 P.M. administrative licensed nurse A expressed that he/she was uncertain if the resident should have remained in the assisted living environment after his/her decline in status. The facility did not provide a policy related to assessments and fall investigations for the Assisted Living environment. The facility failed to ensure this resident received timely and effective interventions for fall prevention after a change in functional ability and multiple falls, which resulted in a fall with a fracture.	S3155		